STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING _____ B. WING _____	02/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTH CARE CENTER	3625 ST JOSEPH ROAD NEW ALBANY, IN47150

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 15, 16, 17, 18, 21, 2011 Facility Number: 000526 Provider Number: 155488 AIM Number: 100266970 Survey Team: Donna Groan RN, TC Gloria Reisert MSW Avona Connell RN Census Bed Type: SNF/NF: 114 Total: 114 Census Payor Type: Medicare: 17 Medicaid: 72 Other: 25 Total: 114 Sample: 23 Supplemental sample: 03 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 2/24/11 by Suzanne Williams, RN	F0000	This Plan of Correction is submitted under the State and Federal Regulations and Statues applicable to long-term care providers. This Plan of Correction does not constitute an admission on the part of the facility. We request this Plan of Correction serve as our credible allegation of compliance.Should you have any questions, please feel free to contact me at (812) 948-0670.Sincerely,Fairley (Lee) R. Taylor Jr. , HFAExecutive Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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F0159 SS=D	Based on interview and record review, the facility failed to ensure residents were notified when their account reached $200 less than the resource limit for 2 of 2 records reviewed for funds in a supplemental sample of 3. (Resident #16 and #25) Findings include: Resident trust accounts were reviewed with the Assistant Business Office Manager on 02/21/11 at 8:49 a.m. She provided a list of residents the facility handles funds for, which included the names of 77 residents. She indicated, she was responsible for resident trust accounts during the Business Office Manager's absence. She provided a printout of the current account balances for the 77 residents. 1.) Resident #16's current balance was listed as $1328.07. Documentation was lacking that the resident or family had been notified the account had reached $200 less than the resource limit of $1500. In interview with the Assistant Business Office Manager, on 02/21/11, at 12:52 p.m., she indicated the resident or family had not been notified and a letter had not been sent.	F0159	This plan of Correction is submitted under State and Federal Regulations and Statues applicable to long-term care providers. This Plan of Correction does not constitute an admission on part of the facility. We request this Plan of Correction Serve as our credible allegation of compliance.It is the practice of this facility to notify each resident receiving Medicaid benefits when their account reaches $200 less than the resource limit .I. Residents # 16 & 25 families were immediately notified on 2/21/11 both by phone call and by letter of the fact their accounts were $200 less than resource limit.II. All residents receiving Medicaid benefits have the potential to be affected. Residents # 16 & 25 families were immediately notified on 2/21/11 both by phone and letter of the fact their accounts were $200 less than resource limit (Attachment A). In addition, all other residents receiving Medicaid benefits accounts have also been reviewed to ensure no one else within $200 less than the resource limit. III. The Area Business Office Manager inserviced the facility Business Office Manager and AR II on the requirements to notify residents/families receiving Medicaid benefits when their accounts reach $200 less than the reource limit (Attachment B).	03/23/2011

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	2.) Resident #25's current balance was listed as $1438.03. The Assistant Business Office Manager indicated the resident or family had not been notified and a letter had not been sent. She indicated the facility policy is to send a letter when the account reaches $200 less than the resource amount. She indicated Medicaid was the payor source for Residents #16 and #25. 3.1-6(b)		The Executive Director and Business Office Manager or designees will review all residents receiving Medicaid benefits accounts weekly to ensure notification made timely.IV. The Excutive Director and Business Office Manager or designees will review all residents receiving Medicaid benefits accounts weekly to ensure notification made timely. All findings will be reviewed in the monthly PI Meeting for 3 months. After 3 months, if 100% compliance is maintained, the PI Committee will determine if furthering monitoring is required.	

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F0279 SS=D	Based on record review, observation and interview, the facility failed to develop a care plan which addressed a resident's constant behaviors of non-stop talking, especially at meal times which was disturbing to tablemates. This deficient practice affected 1 of 20 residents reviewed for care plans in a sample of 23 residents (Resident #33). Finding includes: Review of the clinical record for Resident #33, on 2/17/11 at 11:10 a.m., indicated diagnoses included, but were not limited to, anxiety, Alzheimer disease, dementia with behavioral disturbance, and depressive disorder. Nursing documentation between 10/24/2010 and 2/17/2011 noted entries on a weekly basis in which the resident was constantly talking , including during the day, afternoon and at night. A social service note, dated 1/18/2011, indicated the resident was noted to talk non-stop word salad and was up and down and had interventions in place. Review of the care plans failed to locate a care plan which addressed the resident's non-stop talking.	F0279	It is the practice of this facility to use the results of the assessment to develoop, review and revise the resient's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timeables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessmsnet. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.25, including the right to refuse treatment under §483.10(b)(4).I. Resident #33 was not harmed. Resident #33's care plan has been modified to include resident's behaivors of talking non-stop with loud, fast-paced speech pattern and the following approaches have been added to the plan of care: #8. When resident becomes restless and starts rambling or non-stop talking, assist resident out of the dining room and take her for a walk or assist to lie down. #9. Offer resident a snack of her choosing.II. All resident's with a behaivor have the potential to be	03/23/2011

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	Review of the 9/28/2010 Quarterly Minimum Data Set [MDS] Assessment indicated the resident had no mood problems and occasionally had episodes of wandering and physical abuse during care, but was easily re-directed. Review of the 12/21/2010 Annual MDS Assessment indicated the resident had frequent episodes of trouble concentrating, fidgeting, and sleeping and had episodes of pushing and hitting others. Documentation was lacking on both assessments to indicate the resident had been assessed and triggered for the behavior of constant talking out. The resident did have care plans which addressed her potential to wander with fidgeting/restless; at risk for change in mood with episodes of increased agitation and ambulating for hours; episodes of clinging to peers and seeking assistance; and episodes of resisting care and combativeness, but none of them addressed her constant talking which had the potential to upset others around her. The last review of the resident's care plans was on 12/15/2010. Observations of Resident #33 on		affected. The care plan for residents with behaivors have been audited and the care plan and Monthly Behaivor Monitoring Flowsheet have been modified to reflect any additional approaches and staff have been educated on the revisions to the plan of care.III. The IDT will review the 24 Hour Report Of Resident Change In Condition (see attachment C) and the Monthly Behaivor Monitoring Flowsheets(see attachment D) in the IDT morning meeting 5 times weekly for any new behaivors or behaivors warranting a new or change to the resident's plan of care. All Members of the IDT have been educated on PRO 61005 Comprehensive Plan Of Care (see attachment E).IV. The SSD or designee will review the care plans for residents with behaivors monthly to ensure all behaivors and approaches have been updated and date and initial the care plan when the review is complete. All findings will be reviewed in the monthly PI meeting for 3 months to determine the continued need for monitoring or any changes to achieve 100% compliance.	

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	2/15/2011 at noon and at 5:55 p.m., and on 2/18/2011 at noon, noted the resident to be seated at her table in the secure unit dining room with three other table mates. The residents at her table were observed to become somewhat more restless and frown while staring at her as the resident began to talk out in a loud, fast-paced speech pattern. The resident would stop long enough to answer a staff's question but would then go back to constantly talking. During an interview with QMA #1 on 2/15/2011 at 5:55 p.m., she indicated the resident would go through spurts of being quiet and of talking non-stop, and the resident would answer questions in the middle of her ramblings and then resume her speaking. When queried how the other residents dealt with the resident's constant chatter, the QMA indicated although the staff learned to just accept her rambling on, the other residents sometimes got upset and would yell at her or just look at her with a mad look. 3.1-35(a) 3.1-25(b)(1)			

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F0311 SS=D	Based on record review, observation and interview, the facility failed to ensure a resident received restorative services and needed interventions to prevent further contractures for 1 of 1 resident reviewed with an intervention for the use of splints in a sample of 23. (Resident #83) Findings include: The clinical record for Resident #83 was reviewed on 2/16/11 at 8:05 a.m. The resident's diagnoses included, but were not limited to, rheumatoid arthritis, muscle disorders and dementia. The comprehensive Care Plan, dated 02/13/11, included, but was not limited to: "Restorative Programs: Goal: will prevent further contracture or limitation by splinting daily. Apply spint (sic) to bilat (both) elbows; on with AM care and off after supper; Approach: apply splint to bilat elbows; apply with AM care and remove after supper." On 2/16/11 at 2:50 p.m., Resident #83 was observed seated in a high back wheelchair. There were no splints on either arm. The arms were contracted. On 2/17/11 at 11:30 a.m., the resident was observed seated up in a high back wheelchair. CNA #1 was observed	F0311	It is the practice of this facility to ensure that a resident is given the appropriate treatment and services to maintain or improve his or her abilities.I. Resident #83 was not harmed. MD and family were notified of the absence of bil. elbow splints on 02/16/2011 and 02/17/2011.II. All residents with an MD order for a splint have the potential to be affected. An audit of all residents with a restorative program that includes application of a splint was conducted and the CNA assignment sheets for these residents were updated with the application of the splint and all nursing staff were educated on the addition of the restorative program for splint application to the cna assignment sheet to ensure application per plan of care.III. The schedule for application of splints and the assessment of the area the splint is to be applied to has been added to the TAR for validation and assessment by the licensed nurse. The CNA assighnment sheets have been revisied and reflect the schedule for application of splints and the area to be applied to. All nursing staff have been educated and in-serviced on PRO 66413 Application of Removable, Preformed Splints (see attachment F), CNA assighnment sheets and revision of the TAR for licensed nurses to validate	03/23/2011

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	providing oral care to the resident. The elbow splints were not on at this time. When queried, the CNA was not aware the resident was to have bilateral splints on the arms. On 2/15/11 at 9:45 a.m., Licensed Practical Nurse (L.P.N.) #1 provided the Certified Nurse Assistant (CNA) Assignment Sheet for Hall 300 which included the resident name, room number, activity of daily living and precautions which were to include: "Splinting/ Diabetic/ Smoking/ Seizures/Interventions for risks." The precautions for Resident #83 failed to list the splinting device. On 2/21/11 at 10:10 a.m., LPN #2 provided the Policy and Procedure for the "Application of Removable, Preformed Splints," revised and dated 10/31/06, which included, but was not limited to: "Procedure 10. Update care plan, as necessary. 11. Document in resident medical record splint application and evaluation results before, during, and after splint application...Documentation Guidelines: 1. Record the reason the splint applied and the area the splint was applied to as well as the type of splint that was placed. 1.(sic) The condition of the resident's skin prior to and after placing the splint..." In interview with LPN #1, at		application and assessment of splints. IV. The DNS or Designee will validate the application of splints per resident plan of care five times weekly for one month and initial verification on the Restorative Nursing Program Record below the date, then three times weekly for one month and then twice weekly times one month. All findings will be reviewed in the monthly PI meeting for 3 months to determine the continued need for monitoring or any changes necessary to achieve 100% compliance.	

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	this time, she indicated the Corporate Nurse indicated this policy was the facility's current policy and procedure for the application of splints. 3.1-38(a)(2)			

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F0364	Based on observation, record review and interview, the facility failed to ensure recipes were followed in order to provide food prepared by methods that conserve flavor and appearance, in 1 of 1 observation of pureed food preparation. This deficient practice had the potential to affect 27 residents who received pureed diets. Findings include: On 02/17/11 at 10:23 a.m., cook #1 indicated she was preparing pureed Red Bliss Potatoes for the noon meal. She indicated she would use the recipe for 30 as none for 27 was available. She placed 30 servings of unpeeled potatoes into the Robo Coupe, for processing, with 1-3/4 cup of 2 % milk. The potatoes were then placed in a steam table pan, covered and placed in the steamer. At 11:20 a.m., a copy of the recipes for the Red Bliss Potatoes for the pureed and mechanical diets were reviewed. The recipe for the pureed potatoes indicated in bold capital letters "POTATOES MUST BE PEELED FOR PUREED DIET." The recipe for the Red Bliss Potatoes under the "Recipe Notes: Note: For Mechanical Soft and Dysphasia Diets,	F0364	It is the practice of this facility to ensure all recipes are followed in order to provide food prepared by methods that conserve flavor and appearance.I. The red bliss potatoes were immediately discarded and substituted with mashed potatoes for the pureed diets at lunch meal on 2/17/11. A skills checklist and inservicing over following recipes were immediately started for Cook # 1 by the RD and District Nutritional Services Manager Mentor on 2/17/11.II. All residents receiving pureed diets have the potential to be affected. The red bliss potatoes were immediately discarded and substituted with mashed potatoes for the pureed diets at lunch meal on 2/17/11. A skills checklist and inservicing over following recipes were immediately started for Cook # 1 by the RD and District Nutritional Services Manager Mentor on 2/17/11 (Attachment G).III. The RD, Nutritional Services Manager and District Nutritional Services Manager Mentor have inserviced all cooks over following recipes and have completed skills checklists on all cooks (Attachment H). The RD, Nutritional Services Manager or Designee will directly observe preparation of a pureed dish 5 times a week for 1 month, 3 times a week for 1 month and then at least 1 time a week for 1 month for a total of 3 months with	03/23/2011

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	potatoes must be peeled." On 2/17/11 at 11:20 a.m., the Dietary Manager, after made aware the potatoes were not peeled, indicated the facility would discard the potatoes for the pureed and mechanical soft diets and serve mashed potatoes. 3.1-20(i)(1) 3.1-20(i)(2) 3.1-21(a)(1)		immediate corrective action taken as necessary (Attachment I).IV. The RD, Nutritional Services Manager or designees will directly observe preparation of a pureed dish 5 times a week for 1 month, then 3 times a week for 1 month and then at least 1 time a week for 1 month for 3 months total with immediate corrective action taken as necessary. All findings will be reviewed in the monthly PI meeting for 3 months. After 3 months, if 100% compliance is maintained, the PI Committee will determine if further monitoring is required.	

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F0514	A. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to physician response to pharmacy (Resident #62) hospice notes related to assessments (Resident #83) and hospice discharge notes (Resident #102). This deficient practice affected 3 of 23 residents reviewed for the accuracy and completeness of clinical records in the sample of 23. B. Based on record review and interview, the facility failed to ensure physician orders were transcribed correctly (Resident #21), conversations with the physicians on changes in medication orders were documented (Resident #35), and care plans which addressed a resident's current status remained a part of the clinical record (Resident #26). This deficient practice affected 2 of 23 residents reviewed for physician orders (Residents #21 and #35) and 1 of 23 resident care plans reviewed (Resident #26) in a sample of 23 residents. Findings include: A.1. The clinical record for Resident #62 was reviewed on 2/17/11 at 12 p.m. The resident's diagnoses included, but were not limited to Diabetes, Depression and	F0514	It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident' s assessments; the plan of care and services provided; the results of any preadmission screening conducted by the state; and progress notes. I. Resident #62 was not harmed. The physician reviewed the pharmacy medication recommendation and made no changes to resident #62' s medication regimen. Residents #83 and #102 were not harmed. Hospice provided assessment and discharge notes for residents #83 and #102. Resident #21 was not harmed. The physician and family were notified of the inaccurate physician's orders and a clarification order was obtained from the physician to reflect the current physician's rewrites. Resident #35 was not harmed and the nurse practitioner provided a progress note to reflect the correct modifications to resident #35's progress note. Resident #26 was not harmed and the updated care plan with recent modifications was placed the chart. II. All residents have the potential to be affected. The	03/23/2011

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	Hypertension. A "Note To Attending Physician/Prescribe dated 12/13 2010" which included, but was not limited to: Resident #62 "Dear Dr. [named physician #1] RE: Routine Orders This resident has <23> routine medication orders which account for <30> routine medication administrations a day. Please consider the need for the following medications or any other changes to decrease the number of medication orders. This will decrease the risk of drug interactions, medication costs and save nursing time. 1. Depakote(to treat mood/behavior disturbance) 125mg (milligram) q (every) d (day) 2. Paxil (anti-depressant) 10mg q hs (hour of sleep) 3. Exelon to treat (dementia with Disturbance of mood and psychosis and anxiety) 4.5 mg bid (two times a day) 4. Nemanda (sic) (anti-Alzheimer) 10mg bid 5. Abilify (psychosis and mood stabilizer) 2mg qd 6. Klonopin (anxiety) 0.5mg qd 7. Remeron (anti-depressant) 7.5mg qhs 8. MVI-M (multi-vitamin) qd 9. Vitamin B12 (increase red blood cells) 1000mg IM (intramuscular) q week 10. Vitamin D (strengthen bone) 2000units qd		past 30 days of the Pharmacist's Medication Regimen Review have been reviewed by nursing administration for complete physician's response. Any resident's chart with an order for evaluation or discharge from hospice services have been reviewed for the assessment and discharge notes and made current. All resident's physician's recapitulated orders have been reviewed and revised to include new orders, changed orders or to discontinue orders that have occurred throughout the month. The progress notes from all MD visits since 02/01/2011 have been reviewed for accuracy with the resident's clinical record. The care plans for residents experiencing pain were audited for accuracy and current care plans accessible on the resident clinical record.III. The monthly Pharmacist's Medication Regimen Review Recommendations will be reviewed by the DNS or Unit Manager after completed by the physician and initialed by the designee each month before placing on the clinical record. Hospice services in-serviced their staff on assessments and discharge notes as part of the clinical record and timeliness of documentation placement in the clinical record (see attachment J). All nursing staff has been in-serviced on PRO 62000-15	

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	Physician/Prescriber Response will review and checked AGREE signed and dated 12/31/10." Documentation was lacking in the clinical record of the changes being made to the Medications in question. An additional note was obtained on 2/17/11 at 3:10 p.m. per LPN #1, who faxed the original note to the current physician: which indicated the following: "in reference to this note X changes" and signed by [named physician #2]. A.2. The clinical record for Resident #83 was reviewed on 2/16/11 at 8:05 a.m. The resident's diagnoses included, but were not limited to Dementia and Coronary Artery Disease. A Physician's Order was obtained on 2/1/11 for [named Hospice] to eval (evaluate) and treat. Documentation related to an evaluation from [named Hospice] was lacking. On 2/16/11 at 10:30 a.m., [named Hospice] faxed referral information to the facility. On 2/16/11 at 1:30 p.m., the Administrator provided a copy of the [named Hospice] Nursing Facility Agreement which included, but was not		Renewed or Recapitulated (Recap) Physician's Orders, Medication Records, and Treatment Records (see attachment K). Two nurses of the Nursing administration will review the recapitulated physician's orders for March and for the next 3 months. All progress notes from a physician's visit will be reviewed in the IDT morning meeting with the clinical record for accuracy and initialed and dated on the bottom of the progress note when completed and placed in the clinical record for 3 months. An audit of care plans modified within the last 30 days has been completed to ensure the care plans are current and reflect changes in care, service and treatment and are accessible on the clinical record. The IDT has been in-serviced on PRO 61005 Comprehensive Plan of Care (see attachment E). IV. Any findings from the Consultant Pharmacist's Medication Regimen Review Recommendations follow through will be reviewed monthly in PI meeting for 3 months to determine the continued need for monitoring in monthly PI or any changes to achieve 100% compliance. Hospice services will meet with the DNS or Unit Manager or SSD for an exit conference when assessing residents for admission to their services and on discharge from	

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	limited to: "8. Patient Records Facility and Hospice shall prepare and maintain complete and detailed Patient records in accordance with prudent medical record-keeping procedures and as required by applicable federal and state laws and regulations and Medicare and Medicaid program guidelines...These records shall be readily accessible and systemically organized to facilitate retrieval by either party..." A.3. The clinical record for Resident #102 was reviewed on 2/15/11 at 3:45 p.m. The resident's diagnoses included, but were not limited to Dementia and Adult Failure to Thrive. The resident was admitted to the facility on 11/17/10. The resident was admitted to [named Hospice] on 11/17/10. The resident was discharged from [named Hospice] on 11/26/10. Documentation was lacking in the clinical record of the Discharge Notes. On 2/15/11 at 17:57 (5:57 p.m.) a [named Hospice] employee was in the facility and had the following faxed at this time: Interdisciplinary Hospice communication form which indicated the spouse wanted to revoke hospice care along with the discharge notes. On 2/16/11 at 1:30 p.m., the		their services and the outcome will be documented in the resident progress note before exiting the facility. The Hospice exit conference will be an ongoing performance improvement tool. Any findings will be reviewed in the monthly PI meeting for 3 months to determine 100% compliance or changes to achieve compliance. Any findings from the monthly recapitulated physicians' orders validation will be reviewed in the PI meeting monthly for 3 months to determine the continued need for monitoring or any changes to achieve 100% compliance. Any findings from review of Progress notes form physicians' visits will be reviewed in Monthly PI and for 3 months to determine 100% compliance or any changes to achieve compliance. The DNS or designee will audit the plan of care for residents with significant change and individuals who have been admitted /readmitted for 3 months to ensure accessibility on the clinical record and modification of the plan of care with changes in care, service and treatment. Any findings will be reviewed in the monthly PI meeting for 100% compliance or any changes necessary to achieve compliance.	

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	Administrator provided the "Nursing Facility Services Agreement" for [named Hospice] which included, but was not limited to: "4. Records: 4.1 Compilation of Records A. Preparation. Facility and Hospice shall each prepare and maintain complete and detailed clinical records concerning each Hospice Patient receiving services under this Agreement in accordance with prudent record keeping procedures, their own policies and procedures, and applicable federal and state laws and regulations...."			

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F0514	B.1. Review of the clinical record for Resident #21 on 2/17/2011 at 1:45 p.m., indicated the resident had diagnoses which included, but were, not limited to, hypogammaglobulinem, diaphragmatic hernia, and muscle disorder. On 2/9/2011, the physician signed the February 2011 monthly orders. Review of these orders indicated the resident had an order for Tramadol [for pain] 50 milligrams [mg] every 6 hours as needed [PRN] for pain dated 3/18/2010. On 12/14/2010, nursing notified the physician that the resident had been requesting the PRN pain medication on a regular basis and asked if it could be made routine. A new order for Tramadol 50 mg every evening routinely was then received. Review of the December 2010 to February 2011 MAR [medication administration record] indicated the resident had received the Tramadol routinely. Documentation was lacking of the order having been changed on the monthly physician re-writes to reflect the current order. On 2/18/2011 at 9:00 a.m., the Director of Nursing indicated she had spoken with the	F0514	It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident' s assessments; the plan of care and services provided; the results of any preadmission screening conducted by the state; and progress notes. I. Resident #62 was not harmed. The physician reviewed the pharmacy medication recommendation and made no changes to resident #62' s medication regimen. Residents #83 and #102 were not harmed. Hospice provided assessment and discharge notes for residents #83 and #102. Resident #21 was not harmed. The physician and family were notified of the inaccurate physician's orders and a clarification order was obtained from the physician to reflect the current physician's rewrites. Resident #35 was not harmed and the nurse practitioner provided a progress note to reflect the correct modifications to resident #35's progress note. Resident #26 was not harmed and the updated care plan with recent modifications was placed the chart. II. All residents have the potential to be affected. The	03/23/2011

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	nurse and had her write a clarification order to reflect the current order and update the physician monthly orders. B.2. Review of the clinical record for Resident #35 on 2/17/2011 at 9:30 a.m., indicated the resident had diagnoses which included, but were not limited to, Alzheimer dementia, schizophrenia, depression, and anxiety. On November 5, 2010, the nurse practitioner visited the resident due to her inability to swallow pills. "Under Assessment and Plan", the nurse practitioner documented: "Change of medication regimen is as follows. We will change her Metoprolol to Atenolol [for blood pressure]. We will DC [discontinue] Aggrenox and place on Aspirin 81 mg. [blood thinners]. We will use Exelon patch vs. [versus] pill [for depression]..." Review of the monthly physician orders and the MARs failed to locate documentation of the resident having been on Aggrenox in the first place. An 11/5/2010 nursing note at 0900 [9:00 a.m.] and physician telephone order indicated the following: "D/C Razadyne ER [for depression]. Exelon TD		past 30 days of the Pharmacist's Medication Regimen Review have been reviewed by nursing administration for complete physician's response. Any resident's chart with an order for evaluation or discharge from hospice services have been reviewed for the assessment and discharge notes and made current. All resident's physician's recapitulated orders have been reviewed and revised to include new orders, changed orders or to discontinue orders that have occurred throughout the month. The progress notes from all MD visits since 02/01/2011 have been reviewed for accuracy with the resident's clinical record. The care plans for residents experiencing pain were audited for accuracy and current care plans accessible on the resident clinical record.III. The monthly Pharmacist's Medication Regimen Review Recommendations will be reviewed by the DNS or Unit Manager after completed by the physician and initialed by the designee each month before placing on the clinical record. Hospice services in-serviced their staff on assessments and discharge notes as part of the clinical record and timeliness of documentation placement in the clinical record (see attachment J). All nursing staff has been in-serviced on PRO 62000-15	

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	patch 9.5 1 TD [transdermal] QD [every day] dementia. D/C Metoprolol po [by mouth]. Add Metoprolol 25 mg 1 pill po [by mouth] BID [twice daily]. D/C Prilosec OTC [for stomach]. Add Omeprazole (2mg/ml) [milliliters] 10 ml po Q day." The changes made to the Prilosec and the Omeprazole were not part of the original physician orders given by the nurse practitioner. Documentation was lacking in the nursing notes of the nurse having consulted with the physician to clarify that the resident was not currently on Aggrenox and if he still wanted the resident on Aspirin. Documentation was also lacking in the nursing notes of having spoken with the physician/nurse practitioner to obtain an order for the changes in the resident's stomach medication. During an interview with the DoN on 2/18/2011 at 9:30 a.m., she indicated she had spoken with the nurse who had written the original order on 11/5/2010 and she said she had called the nurse practitioner back when she realized the resident was not on Aggrenox and at that time, the nurse practitioner had given new orders for the resident's stomach medication. The DoN also indicated the		Renewed or Recapitulated (Recap) Physician's Orders, Medication Records, and Treatment Records (see attachment K). Two nurses of the Nursing administration will review the recapitulated physician's orders for March and for the next 3 months. All progress notes from a physician's visit will be reviewed in the IDT morning meeting with the clinical record for accuracy and initialed and dated on the bottom of the progress note when completed and placed in the clinical record for 3 months. An audit of care plans modified within the last 30 days has been completed to ensure the care plans are current and reflect changes in care, service and treatment and are accessible on the clinical record. The IDT has been in-serviced on PRO 61005 Comprehensive Plan of Care (see attachment E). IV. Any findings from the Consultant Pharmacist's Medication Regimen Review Recommendations follow through will be reviewed monthly in PI meeting for 3 months to determine the continued need for monitoring in monthly PI or any changes to achieve 100% compliance. Hospice services will meet with the DNS or Unit Manager or SSD for an exit conference when assessing residents for admission to their services and on discharge from	

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	nurse should have documented her conversations with the nurse practitioner and also have written a clarification order which addressed the Aggrenox and the stomach medications. B.3. Review of the clinical record for Resident #26 on 2/16/2011 at 8:55 a.m., indicated the resident had diagnoses which included, but were not limited to, status post cholecystectomy On 1/22/2011, the resident was admitted to the hospital for abdominal pain which turned out to be her gall bladder and subsequently underwent surgery to remove it. On 1/30/2011, the resident returned to the facility. Review of the nursing notes between 1/30/2011 and 2/16/2011 indicated there were several entries in which the resident verbalized pain or discomfort and received a PRN pain medication. At 3:40 p.m. on 2/17/2011, the DoN was made aware of there being no care plan to address the resident's pain management and after surgical care. She indicated there should have been a care plan to address the pain after surgery. On 2/18/2011 at 9:30 a.m., the DoN presented a copy of the resident's care		their services and the outcome will be documented in the resident progress note before exiting the facility. The Hospice exit conference will be an ongoing performance improvement tool. Any findings will be reviewed in the monthly PI meeting for 3 months to determine 100% compliance or changes to achieve compliance. Any findings from the monthly recapitulated physicians' orders validation will be reviewed in the PI meeting monthly for 3 months to determine the continued need for monitoring or any changes to achieve 100% compliance. Any findings from review of Progress notes form physicians' visits will be reviewed in Monthly PI and for 3 months to determine 100% compliance or any changes to achieve compliance. The DNS or designee will audit the plan of care for residents with significant change and individuals who have been admitted /readmitted for 3 months to ensure accessibility on the clinical record and modification of the plan of care with changes in care, service and treatment. Any findings will be reviewed in the monthly PI meeting for 100% compliance or any changes necessary to achieve compliance.	

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	plan on "pain management' dated 1/30/2011. She indicated that one had been written after the resident came back on 1/30/2011, but that it had been pulled from the record. She also indicated it should have been left a little longer on the resident's chart as her surgery was still recent enough. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3)			